APPENDIX E

NHDS Medical Abstract Fom

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FORM **HDS-1**
(11-12-99)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

MEDICAL ABSTRACT – NATIONAL HOSPITAL DISCHARGE SURVEY

A. PATIENT IDENTIFICATION

1. Hospital number . . . . . ☐☐☐☐

2. HDS number . . . . . ☐☐☐☐

3. Medical record number _____

4. Date of admission . . . . . Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

5. Date of discharge . . . . . Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

6. Residence ZIP Code . . . . ☐☐☐☐☐

B. PATIENT CHARACTERISTICS

7. Date of birth — Month ☐☐ – Day ☐☐ – Year ☐☐☐☐

8. Age *(Complete only if date of birth not given)* . . . . . Units ☐☐☐
1 ☐ Years
2 ☐ Months
3 ☐ Days

9. Sex *(Mark (X) one)*
1 ☐ Male 2 ☐ Female 3 ☐ Not stated

10. Ethnicity *(Mark (X) one)*
1 ☐ Hispanic or Latino 2 ☐ Not Hispanic or Latino 3 ☐ Not stated

11. Race
1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
4 ☐ Asian
5 ☐ Native Hawaiian or Other Pacific Islander
6 ☐ Other *(Specify)* _____
7 ☐ Not stated

12. Marital status *(Mark (X) one)*
1 ☐ Married 3 ☐ Widowed 5 ☐ Separated
2 ☐ Single 4 ☐ Divorced 6 ☐ Not stated

13. Expected source(s) of payment

	Principal *(Mark one only)*	Other additional sources *(Mark all that apply)*
1. Worker's compensation	☐	☐
2. Medicare	☐	☐
3. Medicaid	☐	☐
4. Other government payments	☐	☐
5. Blue Cross/Blue Shield	☐	☐
6. HMO/PPO	☐	☐
7. Other private or commercial insurance	☐	☐
8. Self pay	☐	☐
9. No charge	☐	☐
10. Other *(Specify)* _____	☐	☐

☐ **No source of payment indicated**

14. Status/Disposition of patient *(Mark (X) appropriate box(es))*

Status
1 ☐ Alive → Disposition
- **a.** ☐ Routine discharge/discharged home
- **b.** ☐ Left against medical advice
- **c.** ☐ Discharged, transferred to another short-term hospital
- **d.** ☐ Discharged, transferred to long-term care institution
- **e.** ☐ Other disposition/not stated

2 ☐ Died
3 ☐ Status not stated

(Over)

C. FINAL DIAGNOSES (including E-code diagnoses) (ICD-9-CM codes may be entered if no narrative is available)

Principal: _____

Other/additional: _____

D. SURGICAL AND DIAGNOSTIC PROCEDURES (ICD-9-CM codes may be entered if no narrative is available)

Date of procedure(s)							
Month		Day		Year			

Principal: _____

Other/additional: _____

☐ NONE

Completed by	Date